Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GILBERT MAYORGA, MD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-2148-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
MARCH 17, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary.

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed two units of 99456-SP as part of MMI/IR exams performed on the date above. The exams appear to be two x-rays. Rule 134.204(j)(4)(D)(I) states 'When the examining doctor refers testing for non-musculoskeletal body area(s) to a specialist, then the following shall apply: (I) The examining doctor (e.g., the referring doctor) shall bill using the appropriate MMI CPT code with modifier "SP' and indicate one unit in the units column of the billing form. Reimbursement shall be $50 for incorporating one or more specialists' report(s) information into the final assignment of IR. This reimbursement shall be allowed only once per examination.' Review of the MMI report shows the reports were related to the lumbar spine, which is a musculoskeletal body are not subject to a specialty referral. No payment is due for the code above."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 1, 2013	CPT Code 99456-SP (X2) Designated Doctor Evaluation	$100.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that was already been adjudicated.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.

- 892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

Issues

Did the Designated Doctor bill for the disputed service in accordance with medical fee guideline? Is the requestor entitled to reimbursement?

Findings

According to the explanation of benefits, the respondent denied reimbursement for CPT code 99456-SP (X2) based upon reason code "892."

28 Texas Administrative Code §134.204(j)(4)(D)(iii)(I) states "Non-musculoskeletal body areas shall be billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR. (iii) When the examining doctor refers testing for non-musculoskeletal body area(s) to a specialist, then the following shall apply: (I) The examining doctor (e.g., the referring doctor) shall bill using the appropriate MMI CPT code with modifier "SP" and indicate one unit in the units column of the billing form. Reimbursement shall be $50 for incorporating one or more specialists' report(s) information into the final assignment of IR. This reimbursement shall be allowed only once per examination."

According to the Designated Doctor report, the examination was limited to the lumbosacral spine. Per 28 Texas Administrative Code §134.204(j)(4)(C)(i)(I), (i) Musculoskeletal body areas are defined as follows: (I) spine and pelvis." Therefore, the lumbosacral spine is a musculoskeletal body area. Per 28 Texas Administrative Code §134.204(j)(4)(D)(iii)(I), billing for specialist reports is limited to non-musculoskeletal body areas; therefore, the requestor did not bill for the disputed service in accordance with 28 Texas Administrative Code §134.204. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		11/21/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.